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CHAPTER 1

Human rights and mental illness

On 17 December 1991, the United Nations (UN) General Assembly formally adopted Resolution 46/119, which contains the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991). These principles articulate a range of rights to which individuals with mental illness are entitled, including the right to receive the best available mental healthcare, to live, work and receive treatment in the community, and to access appropriately structured and resourced mental health facilities. Furthermore, mental healthcare should be based on internationally accepted ethical standards and an impartial review body should, in consultation with mental health practitioners, review the cases of involuntary patients.

Although these principles do not have the status of ‘hard law’ and nation states are not obliged to adhere to them, they nonetheless represent an important recognition of the idea that individuals with mental illness require specific protection of human rights for the reason that they are mentally ill, with all of the challenges, difficulties and discrimination that this can bring (Goldman, 2000; Harding, 2000; Kelly, 2001). This chapter begins by describing the gradual emergence of this idea, commencing with the development of the concept of human rights and the emergent relationship between mental illness and the language of human rights during the 19th century. This is followed by a consideration of the UN’s Universal Declaration of Human Rights (adopted in 1948) and subsequent expressions of human rights values in international legislative forms, including the Council of Europe’s European Convention on Human Rights (ECHR) (drafted in 1950) (Council of Europe, 1950). The ECHR was given further effect in the UK through the Human Rights Act 1998 and in Ireland through the European Convention on Human Rights Act 2003.

The purpose of this discussion is to describe one element of the legislative background (i.e. the human rights element) against which new mental health legislation has been or is being developed in England and Wales (Mental Health Act 2007), Ireland (Mental Health Act 2001), Scotland (Mental Health (Scotland) Act 2015) and Northern Ireland

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(Mental Capacity Bill 2015). Finally, this chapter presents and examines relevant provisions of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991) and the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006).

What are human rights?

Early philosophies of human rights

A right is an entitlement, a thing that one may legally or morally claim (Pearsall & Trumble, 1996: p. 1240). The term ‘human rights’ refers specifically to rights that a human being possesses by virtue of the fact that he or she is a human being (Edmundson, 2004; Ishay, 2004; Hunt, 2007). Human rights do not need to be earned or granted; they are the birthright of all human beings simply because they are human beings – no other qualification is required. The best way to understand the key philosophies of human rights is through a brief examination of the evolution of contemporary conceptualisations of human rights and the philosophies underpinning key developments in the field.

One of the earliest secular statements of human rights was issued by Cyrus the Great, King of the Achaemenid Persian Empire in the 6th century BC, and contained references to entitlements to security, liberty, freedom of movement, property ownership, and certain social and economic rights (O’Sullivan, 1998). Although it is unclear to what extent these principles were observed in practice, and whether they applied to all individuals, this statement of entitlements was nonetheless conceptually significant, and many of its principles were later reflected in both the Universal Declaration of Human Rights and the Universal Islamic Declaration of Human Rights (Islamic Council, 1981). As a result, these concepts remain central to the key philosophies of human rights today. There is also now a specific tradition of mental health law in Islamic psychiatric and legal tradition (Dols, 1987; Pridmore & Pasha, 2004; Dols, 2007).

At around the same time that Cyrus the Great issued his statement of entitlements, the Chinese philosopher Confucius (551–479 BC) outlined a philosophy that encompassed certain aspects of what are now described as human rights, including the idea that all people should have access to education and that government should take specific steps to ensure the social and moral welfare of its people (Chang, 1998). Consistent with this, Greek philosophers Socrates (469–399 BC) and Plato (428–347 BC) postulated the existence of a universal view of human goodness, forming the basis for an early version of human rights (Ishay, 2004). Aristotle (384–322 BC) believed that virtue lay at the heart of a good human life and placed strong emphasis on the individual’s psychological and behavioural commitment to engage with the world in a virtuous fashion that promoted the common good.

Marcus Tullius Cicero (106–43 BC), a Roman statesman and legal scholar, also accorded substantial importance to the actions and reasoning of the individual in respect of the common good. Cicero postulated the existence of a natural law that was applicable to all men, in accordance with nature and unchanging over time (Cicero, 54–51 BC). This conception of natural law confirmed the uniqueness and dignity of each individual, and emphasised the need for individuals to act in the service of others and of society in general.

From a philosophical perspective, the idea of 'natural rights' is one of the key theories of rights that remains both relevant and contested today (Freeman, 2002: pp. 18–22). Cicero's conception of universal justice was consistent with the foundation texts of many philosophical, religious and spiritual traditions, most of which contain teachings about individuals' entitlements and responsibilities which could now be interpreted as reflecting concepts and values that correspond to contemporary human rights.

René Cassin, one of the key architects of the Universal Declaration of Human Rights, noted the particular relevance of Jewish principles of justice (Ishay, 2004), which echo earlier concepts outlined in Hammurabi's Code, the oldest body of laws still in existence, but broaden the application of these principles to include both Jews and gentiles. Similarly, in Islamic tradition, the Qur'an outlined analogous principles of respect, solidarity and justice, and literature based on Buddhist philosophy in India contains myriad expressions of similar philosophical principles (Ali, 1989).

The Enlightenment: the philosophy of secular human rights

The more immediate philosophical roots of the secular human rights movement lie in the 18th-century Enlightenment, which saw a decline in the influence of the Roman Catholic Church in Europe and the birth of new attitudes with ostensibly greater roots in secular rationality. Thomas Hobbes (1588–1679) believed that every individual had the right to life and that entering into a form of social contract with other people could deepen the protection of this basic, natural right.

From a philosophical perspective, this idea of the 'social contract' remains one of the key underpinnings of human rights thought today (Hunt, 2007: p. 285) and can be traced clearly to England's Habeas Corpus Act 1679, which aimed to protect the individual from violations of personal liberty by the state (e.g. wrongful imprisonment) (Adams, 1912). The Habeas Corpus Act 1679 built on the provisions of both the Petition of Right 1628, which confirmed 'the diverse rights and liberties of the subjects', and, to a lesser extent, the Magna Carta (1215), which guaranteed the right to a free trial for freemen.

The English Bill of Rights 1689 further endorsed the rule of law and underlined the importance of 'the true, ancient and indubitable rights and liberties of the people of this kingdom'. It placed particular emphasis on the need to protect the individual from unduly harsh treatment by the state, with a specific prohibition of 'cruel or unusual punishments'. In 1689–1690, John Locke (1632–1704) published his *Letter Concerning Toleration*, which asserted the individual's right to freedom of religion (Locke, 1689), and his *Second Treatise of Government*, which balanced the individual's natural right to preserve their own life with their duty to preserve the lives of others (Locke, 1690).

According to Locke, the state had the right to make and enforce laws provided that it acted in a fashion consistent with the trust placed in it: this was the 'social contract'. Seven decades later, Jean-Jacques Rousseau (1712–1778), a Swiss-French philosopher and social critic, published *The Social Contract* (1762), in which he argued that while an individual's private interests may differ from the social interest, the individual still benefitted from entering a social contract that protected civil rights, such as the right to legally own property. With Rousseau, the 'social contract' became a key iconic feature of philosophies of human rights.

The USA and France: a political philosophy of individual rights

In 1776, Thomas Paine (1737–1809), an English writer and revolutionary, produced an influential pamphlet entitled *Common Sense*, in which he called for equal rights for all citizens. A political philosophy of individual rights was further endorsed by the US Declaration of Independence in July 1776. This Declaration had, in turn, a substantial influence on the drafting of the US Constitution of 1787 and, in particular, the first ten amendments, known collectively as the Bill of Rights (1791). Despite the conceptual and rhetorical advances represented by the Constitution and Bill of Rights, however, it is apparent that these rights and principles were not necessarily universal, as, for example, the Constitution still left the issue of slavery at the discretion of individual states.

Moreover, the framers of the Declaration of Independence, by stating that certain 'truths' were 'self-evident', presupposed the existence of self-evident, natural rights which, by implication, stemmed from Cicero's philosophy of natural law, applicable everywhere and to all. The philosophy of natural law was strongly opposed by the English philosopher and jurist Jeremy Bentham (1748–1832), who argued that natural law was entirely without basis and proposed adapting the principle of utility (or net benefit) when assessing human laws and actions (Welch, 1984). Over a century later, writing in the context of the Universal Declaration of Human Rights, Macdonald (1963) similarly suggested that natural rights had no apparent basis in nature, were essentially the product of human choices and provided no 'natural' basis for theories of human rights. Nonetheless, the idea of 'natural rights' is still a key element of the philosophy of human rights in practice in many countries.

Another, later philosophy of human rights stems from the idea that they are rooted human nature, i.e. a combination of shared observations about the state of being human, including, for example, the existence of

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human needs and an individual sense of human dignity. On the basis of considerations such as these, Nussbaum (1992, 2000) developed a theory of human 'capabilities' in which, for example, the ability of the individual to reason suggests the existence of a right to protect the individual's freedom of conscience. As a general basis for governing human conduct, however, this theory presents significant difficulties, including its minimal guidance on (i) making difficult moral distinctions between what is 'good' and 'bad' (Freeman, 2002) and (ii) reaching resolution when the needs of one person are incompatible with those of another (Gray, 1986).

Notwithstanding these philosophical controversies over concepts of 'natural' rights, which emerged in the 18th century and persist to this day, the French Revolution of 1789–1799 was to prove an important step forward for the formal recognition of individual human rights in Europe, culminating in the adoption of the *Déclaration des droits de l'homme et du citoyen* (Declaration of the Rights of Man and of the Citizen) by the Assemblée Nationale Constituante (National Constituent Assembly) in August 1789.

The French Declaration transformed the language of human rights, and while its text did not win universal approval, criticisms such as that launched by Edmund Burke (1729–1797) in 1790 tended to generate swift and emphatic defences from writers such as Mary Wollstonecraft (1759–1797) and Thomas Paine, in his celebrated *Rights of Man* (1791). Notwithstanding these defences, however, there was still clear room for expansion of the principle of universalism, and in 1791 the French writer Olympe de Gouges (born Marie Gouze, 1748–1793) wrote an outspoken *Déclaration des droits de la femme et de la citoyenne* (Declaration of the Rights of Woman and of the Citizen), and the English writer Mary Wollstonecraft followed suit in 1792 with *A Vindication of the Rights of Woman*.

As both de Gouges and Wollstonecraft warned, the exclusion of women and other groups from these declarations of rights was to prove a particularly problematic legacy of 18th-century rights movements. In the UK, the exclusion of certain groups from voting rights came to particular prominence in the early 1800s, as William Lovett (1800–1877), a London political activist, published *The People's Charter* (1838), which recommended that every person over 21 years of age should be entitled to vote (Thompson, 1971). These developments highlight another of the key features of many philosophies underlying human rights that remains highly relevant today: equality (Freeman, 2002: pp. 107–108).

Despite the popularity of the Chartist and similar movements, voting rights were not extended to all male citizens until the end of the 19th century and the struggle for votes for women was to continue into the 20th century. Gradually, however, the suffragette movement attained voting rights for women in various countries around the world, including New Zealand (1893) and Norway (1913) and, eventually, the UK (1918) and USA (1920). In the USA, the exclusion of slaves from the new language of rights had already led to the American Civil War (1861–1865), resulting in three new amendments to the US Constitution, abolishing slavery (Thirteenth Amendment), extending federal legal protections to all citizens regardless of race (Fourteenth Amendment) and abolishing racial restrictions on voting (Fifteenth Amendment).

Overall, then, the key philosophies of human rights underpinning the emergence of contemporary ideas of rights included natural law, the idea of a social contract, the principle of equality, and some of the philosophies informing recurring critiques of human rights, such as those laid out by Burke and Bentham. Many of these philosophical debates continue today and are unlikely ever to be resolved definitively. This, arguably, is an essential feature of human rights discourse: a diversity of philosophies is necessary to ensure that concepts of human rights remain relevant and applicable as societies evolve and change over time.

Mental illness and human rights in the 19th century

One of the groups not specifically mentioned in these declarations of rights were those with mental illness. Historical evidence suggests that throughout the course of the 18th and 19th centuries, individuals with mental illness in much of Europe tended to live lives of poverty and destitution, generally untouched by changing trends in political thought (Psychiatrist, 1944; Shorter, 1997). In 1817, the House of Commons of the United Kingdom of Great Britain and Ireland set up a Select Committee to examine the state of ‘the lunatic poor in Ireland’ (Reynolds, 1992). The Right Honourable Denis Browne (a Mayo Member of Parliament) gave evidence about the fate of people with mental illness in rural Ireland:

> ‘There is nothing so shocking as madness in the cabin of the peasant, where the man is out labouring in the fields for his bread, and the care of the woman of the house is scarcely sufficient for the attendance on the children. When a strong young man or woman gets the complaint, the only way they have to manage is by making a hole in the floor of the cabin not high enough for the person to stand up in, with a crib over it to prevent his getting up, the hole is about five feet deep, and they give the wretched being his food there, and there he generally dies. Of all human calamity, I know of none equal to this, in the country parts of Ireland which I am acquainted with’ (Select Committee on the Lunatic Poor in Ireland, 1817: p. 23).

In Ireland, which was a predominantly Catholic country, the Catholic Church played little role in providing for the mentally ill during this period, although there is evidence that it did not support witch hunts against individuals with mental illness in Ireland (such as occurred in many European countries) (Robins, 1986). In England and Wales, by contrast, there is greater evidence of proactive involvement of religious groups in providing for the mentally ill. In 1792, for example, following the death of a Quaker woman in the York Lunatic Asylum, William Tuke, himself a Quaker, founded the Retreat, a private hospital for individuals with mental illness (Torrey & Miller, 2001). Fifty years later, the Anglican Church played

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a pivotal role in establishing the list of subscribers for the North Wales Lunatic Asylum in Denbeigh (in the 1840s), when members of the Bible Society were also recruited for door-to-door collections (Michael & Hirst, 1999; Andrews & Scull, 2002).

Consistent with this difference between the attitudes of the Catholic Church in Ireland and those of religious groups in various parts of Great Britain, there is evidence that differences between Catholic and Protestant groups in Ireland had significant impacts on both asylum life and interpretations of mental illness. Up until 1904, for example, all of the physicians and staff at Ballinasloe Asylum (in the west of Ireland) were Protestant, whereas over 90% of patients were Catholic (Walsh, 1999). Irish Protestants tended to attribute mental illness resulting from 'religious excitement' to certain features of Roman Catholicism, although records from Ballinasloe Asylum would appear to suggest that 'religious excitement' was, in fact, more common among Protestants than among Catholics at this time.

Notwithstanding the varying responses of religious groups to the problems presented by the large numbers of mentally ill persons in need of medical and social care, philanthropic and governmental responses were remarkably consistent across Europe and the USA, as public authorities moved swiftly to establish large institutions dedicated to accommodating this 'hurried weight of human calamity' (Hallaran, 1810), providing shelter, food and (later) various forms of 'treatment'.

The expansion in asylum populations was particularly notable in England and Ireland: in 1859, there were 1.6 asylum inmates per 1000 population in England, and by 1909 this had risen to 3.7 per 1000 (Shorter, 1997). In Ireland, there were 3234 individuals in asylums in 1851, and by 1914 this had risen to 16 941 (Williamson, 1970; Walsh & Daly, 2004; Kelly, 2008*a*). This expansion in asylum populations was attributable to both governmental concern about the social problems presented by the mentally ill and the philanthropic impulses of 19th-century social activists.

The relative absence of mental illness from human rights discourse throughout this period is probably related to a number of factors, including the absence of clear definitions of 'lunacy' or mental illness, the paucity of effective treatments, stigma associated with mental illness, and the resultant exclusion of individuals with mental illness from most forms of political and societal discourse (Shorter, 1997; Kelly, 2005, 2006a; Scull, 2005). Ironically, it is likely that the era of institutionalisation in the late 19th century represented a time when there was a particular need to focus on the human rights of the mentally ill, especially given the close relationship between mental health policy and the exercise of governmental power in the form of involuntary detention and treatment (Gostin & Gable, 2004).

The dramatic increase in numbers of patients detained in asylums in the 19th century certainly represented a significant exercise of governmental power, and while generally motivated by humanitarian concerns, this development was to bring myriad problems chiefly related to involuntary admission processes that often resulted in lengthy periods of detention in large public asylums, at least some of which were severely overcrowded and poorly therapeutic.

In addition, admission to asylums was, in both England and Ireland, generally possible only on an involuntary basis, and the most common pathways into asylums involved criminal as opposed to civil processes in the courts: in Ireland, for example, the Criminal Lunatics (Ireland) Act 1838 provided that individuals who were considered to be dangerous could be detained indefinitely at the behest of two justices of the peace, who had the option of using medical evidence to inform their decision (but did not have to). As the 19th century progressed, it was readily apparent that the 'dangerous lunacy' procedures were commonly misused, resulting in lengthy, inappropriate detentions in ill-suited institutions (Kelly, 2008*b*). The situation in England was similar, with an emphasis on involuntary as opposed to voluntary admission and a strong trend towards increased rates of detention (Torrey & Miller, 2001).

In theory, the emerging interest in the protection of the civil and political rights of all human beings throughout the 18th and 19th centuries should, automatically and without discrimination, have included the protection of the civil and political rights of individuals with mental illness. The historical experiences of the mentally ill, however, and especially their increased rates of incarceration, highlight the need for proactive consideration of the human rights of this group, especially when they may lack capacity, opportunity or facility adequately to assert these rights for themselves. The need to provide dedicated safeguards for the rights of the mentally ill was not to be substantively recognised in the 19th century, however, as formal declarations of human rights did not include specific consideration of increased risks to the civil and political rights of people with mental illness until well into the 20th century.

Human rights in the early 20th century

The tumultuous events of the early decades of the 20th century resulted in significant political change throughout Europe and directed increased attention to the concept of human rights. Following the end of the First World War (1914–1918), the League of Nations (an international organisation founded to prevent further war) oversaw the establishment of several newly independent states in Europe and there was, in at least some countries, recognition of a need for particular protections for the rights of specific groups. The 1918 Russian Declaration of the Rights of the Working and Exploited People (*Deklaratsia prav trudyashchegosya i ekspluatiruemogo naroda*), for example, focused on workers' rights and aimed 'to abolish all exploitation of man by man, to completely eliminate the division of society into classes, to mercilessly crush the resistance of the exploiters' (Lenin, 1918; quotation from 1964 reprint: p. 423). Typically, this document blended the general language of human rights with the more specific and occasionally colourful language of the political values its authors sought to promote (i.e. communism).

Two decades later, the advent of the Second World War (1939–1945), commencing with the German invasion of Poland in September 1939, highlighted the fragility of the uneasy world order that was established after the First World War and demonstrated the need for stronger international mechanisms to prevent the emergence of conflict between nations, resolve disputes as they arise, and protect individual human rights both within and across national borders. In 1941, in the midst of the Second World War, Franklin D. Roosevelt, President of the United States, outlined ‘four essential human freedoms’ in an influential address to the US Congress; these were: ‘freedom of speech and expression’, ‘freedom of every person to worship God in his own way’, ‘freedom from want’ and ‘freedom from fear’ (Roosevelt, 1941; quotation from 2005 reprint: p. 359).

In light of the unprecedented destruction and atrocities of the Second World War, a new international body was founded to replace the League of Nations, promote international peace and security, and reduce the possibility of further world wars. The United Nations was formally established on 24 October 1945 with the ratification of the Charter of the United Nations by the five permanent members of the UN Security Council: the USA, UK, Republic of China, Union of Soviet Socialist Republics (USSR) and France. The Charter built on previous dialogue and agreements reached in the 1942 Declaration by United Nations and at the 1944 Dumbarton Oaks Conference in Washington, DC. One of the primary aims of the new organisation was to articulate an intellectual and legal framework to support the observance of human rights among member states and promote a culture of human rights in the world.

The Universal Declaration of Human Rights

The Declaration

To promote its goals through an international bill of rights, the UN created the UN Commission on Human Rights in 1946, and a final draft of the Universal Declaration of Human Rights was adopted by the UN General Assembly at Palais de Chaillot in Paris on 10 December 1948 (Morsink, 1999; Ishay, 2004). The Declaration was presented as a non-binding statement of rights and ratified by 50 of the 58 UN member states; the Byelorussian SSR, Czechoslovakia, Poland, Saudi Arabia, South Africa, the Ukrainian SSR, the USSR and Yugoslavia abstained.

The Universal Declaration of Human Rights comprises 30 articles, preceded by a short preamble stating that ‘recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’ and that ‘it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law'. Article 1 states that 'all human beings are born free and equal in dignity and rights' and Article 2 establishes the universal nature of these rights: 'Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.

This emphasis on universality was both useful and necessary, not least because previous declarations of rights had commonly been interpreted in such a way as to exclude certain groups (e.g. women). The UN Declaration provided a list of factors that explicitly were not to form the basis of discrimination in relation to rights. Although mental illness was not specifically mentioned in this list, the universal spirit of the Declaration was beyond doubt and its exhortation against discrimination on the basis of 'other status' can reasonably be interpreted as including discrimination on the basis of mental illness. In 1991, the UN made this more explicit in its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (see pp. 28–29 below).

Articles 3 to 19 of the Universal Declaration of Human Rights articulate a range of rights fundamentally rooted in the principle of liberty, including 'the right to life, liberty and security of person'. The explicit articulation of this right, especially in the context of universal rights, is particularly relevant to people with mental illness, not least because of their increased risk of lengthy involuntary detention in various institutions. Again, the need to respect the right to liberty, along with the other rights outlined in the Universal Declaration of Human Rights, was strongly re-emphasised in 1991 in the UN's Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

Articles 20 to 26 of the Universal Declaration of Human Rights outline rights related to equality and political participation: Article 23 provides for the individual's 'right to work'; Article 25 states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family'; and Article 26 provides 'the right to education' which 'shall be free, at least in the elementary and fundamental stages'.

Articles 27 and 28 outline social and cultural rights 'to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits' within the context of 'a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized'. Finally, Articles 29 and 30 outline the overall principles governing the observance of these human rights, including the provision that these rights 'shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society'.

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Controversies relating to the Universal Declaration of Human Rights

In the seven decades since its adoption, the Universal Declaration of Human Rights has proven both an influential and a controversial document. In terms of controversy, the eight countries that abstained from ratifying the Declaration at the outset in 1948 expressed immediate concerns about both specific rights (e.g. freedom of movement) and the possibility that the non-binding Declaration might challenge domestic jurisdictions (Ishay, 2004).

This concern was compounded by the perceived Western bias of the Declaration (Cassese, 1992), with some commentators seeing the Declaration as a reinforcement of the political values of the USA and Western Europe, with limited applicability to other areas of the world (Pollis & Schwab, 1980). More specifically, some Islamic commentators were concerned that the Declaration failed adequately to reflect Islamic culture, religion and tradition; as a result, on 5 August 1990, representatives of 45 Islamic countries in the Organization of the Islamic Conference adopted an alternative declaration of rights, the Cairo Declaration on Human Rights in Islam (Organization of the Islamic Conference, 1990).

The Universal Declaration of Human Rights also generated controversy owing to the exclusion of certain rights, such as an explicit right to conscientious objection. The Irish politician and Nobel Peace Prize winner Seán MacBride (1904–1988) emphasised this omission in his 1974 Nobel lecture and suggested that ‘the right to refuse to kill’ be added to the Declaration (MacBride, 1997). Various other rights that were not accorded prominence in the Universal Declaration of Human Rights have also become the subjects of increasing concern over the years. These include the right to a clean environment (Tomuschat, 2008) and the rights of specific groups such as gay, lesbian and transgender individuals (Smith, 2007). Some of these criticisms can be addressed, at least in part, through appeal to other rights in the original Declaration (such as rights to life or to freedom of opinion and expression), but they also reflect the ongoing and legitimate evolution of concepts of rights since the Declaration was agreed.

Other controversies have focused on the inclusion of certain rights, especially economic and social rights, in the Declaration. Whereas civil and political rights are primarily concerned with protection of the individual from undue interference by the state and facilitation of participation in civil and political life without repression or discrimination, economic and social rights are primarily concerned with socioeconomic matters as they relate to the individual, such as rights to food, housing and health.

There is considerable controversy over just how justiciable such rights truly are, given their inevitable relationship with a state’s political and economic situations (Freeman, 2002; Neier, 2006). Their inclusion in the Universal Declaration of Human Rights was the subject of considerable debate during the initial drafting process (Morsink, 1999) and this

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persistent concern (Puta-Chekwe & Flood, 2001) resulted in the adoption of two separate covenants by the UN General Assembly in 1966: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

One of the key differences between these covenants was the immediacy with which these two categories of rights were to be observed: civil and political rights were to be implemented immediately, whereas social and cultural rights were to be implemented progressively, consistent with other national programmes. In other words, the realisation of social and cultural rights was explicitly dependent on a range of other factors, such as policy programmes in specific states, economic plans, processes of national development, and broader programmes of political action and development.

The importance of political context in the implementation of human rights was immediately apparent following the adoption of the Universal Declaration of Human Rights. The Cold War between the USA and the USSR (1940s to 1990s) presented immediate and substantial problems as both sides failed meaningfully to engage with binding human rights treaties, but did not hesitate to use the rhetoric of human rights for their own political purposes (Forsythe, 1995; Freeman, 2002; Ishay, 2004).

Notwithstanding these difficulties, there were some developments throughout the 1960s and 1970s, including, in 1967, the adoption of Resolution 1235 of the Economic and Social Council (permitting discussion of human rights violations in specific countries) and, in 1976, the establishment of the Human Rights Committee. There was also significant growth in non-governmental human rights activity in various countries during this period (e.g. Charter 77 in Czechoslovakia) (Bugajski, 1987; Havel, 2008), some of which contributed to the decline of communist political systems in Europe and elsewhere (Donnelly, 1998; Forsythe, 2000).

Following the end of the Cold War in the early 1990s, there was further expansion of public and academic human rights discourse, but also some notable failures on the part of the international community, and the UN in particular, to act to protect basic human rights in several settings (e.g. Yugoslavia in the late 1990s) (Power, 2002, 2008). The ongoing importance of political contexts in the observance of human rights was further underlined following the terrorist attacks of 11 September 2001 in the USA, when governmental responses resulted in significant restrictions on civil liberties and, arguably, a certain erosion of legal culture in the USA among other places (Tomuschat, 2008).

Mental illness and human rights in the 20th century

Notwithstanding the various challenges to the emergence of human rights discourse during the 20th century, this period saw the first signs that the new language of human rights might have some positive implications for individuals with mental illness, if only by drawing greater attention

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to the ever-increasing numbers detained indefinitely in large psychiatric institutions, many of which lacked appropriate, non-restrictive, therapeutic facilities (Walsh & Daly, 2004). The subsequent increase in governmental and public concern about mental illness was accompanied by a renewed emphasis on the search for new treatments and management strategies, rather than simple, interminable institutionalisation.

This therapeutic enthusiasm found its roots in the work of 19th-century psychiatrists such as Wilhelm Griesinger (1817–1868) and Emil Kraepelin (1856–1926), who precipitated a revolution in psychiatric taxonomy by differentiating between the syndromes of dementia praecox (schizophrenia) and manic depression (bipolar affective disorder). As a result of these and other developments, the early decades of the 20th century saw the emergence of novel, often controversial treatments such as insulin coma therapy and electroconvulsive therapy. Not all of these treatments have stood the test of time and some, such as lobotomy, were undoubtedly used with unjustified enthusiasm and tragic results (Shorter, 1997; El-Hai, 2005). This was, nonetheless, a period of distinct therapeutic enthusiasm that also saw the emergence of psychoanalysis, pioneered by Sigmund Freud (1856–1939) in Vienna and London, and readily adaoted by psychiatrists and psychologists throughout Europe and, especially, the USA (Shorter, 1997; Torrey & Miller, 2001; Porter, 2002).

As the 20th century progressed, there were also significant developments in relation to mental health legislation. In Ireland, for example, the Mental Treatment Act 1945 introduced several important reforms by (a) establishing a process of voluntary admission to psychiatric facilities; (b) underlining and strengthening the mandatory role of medical practitioners in certifying involuntary admissions; (c) reforming the processes whereby individuals could be transferred to in-patient forensic psychiatric care; and (d) making myriad changes to the administration and governance of psychiatric facilities (Kelly, 2008*c*).

By this time, Great Britain (1930) and Northern Ireland (1932) had already introduced novel mental health legislation, which, among other measures, established new procedures for voluntary admission to psychiatric in-patient facilities (O'Neill, 2005). Consistent with these relatively enlightened reforms, the therapeutic enthusiasm of the 20th century reached a peak in the early 1950s, when Jean Delay and Pierre Deniker published clinical data supporting the usefulness of chlorpromazine for the treatment of psychosis, thus establishing it as the first effective medication for the treatment of schizophrenia (Shorter, 1997).

Notwithstanding these developments, many countries saw the number of people detained in asylums continue to increase as the 20th century progressed. In Ireland, the number of psychiatric in-patients peaked in 1958, but was still notably slow to decline after that: even in 1961, one in every 70 Irish people above the age of 24 was resident in a psychiatric hospital (Lyons, 1985; Healy, 1996). In the UK, the 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the 'Percy

Commission') attempted to open a new era of 'community care' by declaring that:

> 'No patient shall be retained as a hospital in-patient when he has reached the stage at which he could return home if he had a reasonably good home to go to. At that stage the provision of residential care becomes the responsibility of the local authority' (Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1957).

Over the following decades, considerable progress was made dismantling traditional institutional and residential care structures in the UK, although the development of community-based alternatives was criticised as being too slow and inadequate (Fadden *et al*, 1987; Dyer, 1996). In Ireland, a similar process of deinstitutionalisation also commenced, with a substantial reduction in the number of in-patient beds and renewed emphasis on the development of community facilities. As in the UK and USA, however, concern has been consistently expressed about the adequacy of social and community provision, especially for individuals with enduring illnesses such as schizophrenia (Mollica, 1983; Fadden *et al*, 1987; Dyer, 1996; Kelly, 2004*a*, 2005).

Notwithstanding these generally positive developments, the first half of the 20th century did not see the emergence of any explicit, systematic or binding recognition of a need for specific protections for the human rights of individuals with mental illness. Indeed, for much of the early 20th century, large numbers of individuals remained detained in psychiatric institutions; certain treatment initiatives appear to have been deployed excessively or inappropriately (El-Hai, 2005); there was little evidence of social reintegration or political empowerment of individuals released from asylums; and – to this day – there remain large parts of the world in which psychiatric practices are largely untouched by any of these legislative and therapeutic developments (Bloch & Reddaway, 1977, 1985; Munro, 2000, 2002, 2006; Callard *et al*, 2012).

Ultimately, clear recognition of the need to provide specific protections for the rights of the mentally ill was not to take shape until the latter half of the 20th century and, when it occurred, this development largely found its roots in international declarations of rights, including the Universal Declaration of Human Rights (1948), the European Convention on Human Rights (1950) and, eventually, the UN's Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991).

The European Convention on Human Rights

The Convention

In 1950, the Council of Europe adopted the Convention for the Protection of Human Rights and Fundamental Freedoms (also known as the European

Convention on Human Rights (ECHR)), which aims to protect human rights and the fundamental freedoms 'which are the foundation of justice and peace in the world and are best maintained on the one hand by an effective political democracy and on the other by a common understanding and observance of the human rights upon which they depend' (Council of Europe, 1950: Preamble).

Consistent with the Universal Declaration of Human Rights, section I of the EHCR outlines a range of individual rights, including rights to life (Article 2) and to liberty, security and a fair trial (Article 5); respect for private and family life (Article 8); freedom of thought, conscience, religion (Article 9), expression (Article 10), assembly and association (Article 11); the right to marry (Article 12); and the right to 'an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity' (Article 13). There are also prohibitions on torture (Article 3), slavery, forced labour (Article 4), discrimination (Article 14) and abuse of rights (Article 17).

Unlike the Universal Declaration of Human Rights, the ECHR established a binding legal mechanism for the enforcement of these rights, the European Court of Human Rights (Article 19), which was founded in January 1959 and by December 2007 held jurisdiction over 47 states. The number of applications to the Court has increased steadily since the 1970s, and in 2007 there were 49 750 applications, of which approximately 26 000 were dealt with judicially: over 24 000 applications were declared inadmissible or struck off the list and 1649 judgments were delivered (Tomuschat, 2008).

Notwithstanding these various challenges, the European Court of Human Rights has become the international front-runner in legislating for human rights and a model for similar initiatives elsewhere. There are, however, significant problems related not only to the limitations on financial and institutional resources for the Court, but also to enforcement of judgments, especially when findings may be attributable to deficits in domestic legal order in relevant states (Tomuschat, 2008). In addition, many of the rights outlined in the ECHR are subject to various limitations and qualifications, all of which require interpretation (Wadham *et al*, 2007).

Overall, there is some evidence that the ECHR has provided enhanced protection of basic human rights in ratifying states (Smith, 2007) and, more specifically, helped emphasise certain important legal principles, such as the positive obligation of public bodies to take reasonable operational measures to prevent violations of ECHR rights (Wadham *et al*, 2007). On this basis, Smith (2007) contends that the ECHR has matured to become the most effective and sophisticated human rights treaty in the world, and has generated the most comprehensive jurisprudence on human rights. This positive assessment is not universally agreed (Letsas, 2007) and the ECHR is, moreover, a victim of its own popularity, as demands on the Court continue to increase, resulting in delays and inefficiencies (Helfer, 2008).

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The solution to these problems may lie, at least in part, in efforts to ‘embed’ the principles of the ECHR more deeply in national political and judicial decision-making, thus reducing the need for individuals to apply to the European Court of Human Rights with their complaints (Helfer, 2008). This kind of enhanced recognition of the ECHR at national level might be achieved in a number of ways, not least through the implementation of national legislation, such as the Human Rights Act 1998 in the UK, which clearly reflect the principles of the ECHR (see pp. 22–24 below).

The ECHR in relation to mental illness

There is now a significant body of jurisprudence in relation to mental illness and the ECHR (Perlin *et al*, 2006*a*,*b*; Bartlett *et al*, 2007). The European Court of Human Rights delivered its first significant decision in relation to mental disability in 1979 and has remained active in this area ever since: between 2000 and 2004 the Court delivered over 40 judgments relating to mental disability and various issues related to psychiatric detention (Bartlett *et al*, 2007). A wide range of issues has been addressed by the Court over this period, many of which concern (a) involuntary detention owing to mental illness, (b) conditions while detained and (c) review of involuntary detention.

Involuntary detention owing to mental illness

A number of cases before the European Court of Human Rights have centred on alleged breaches of Article 5(1) of the ECHR which states:

> ‘Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law [including] (e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants’.

One of the most widely cited cases to have come before the court on this matter was *HL v UK (Bournewood)* [2004], which centred on an individual with severe intellectual disability who was compliant while in hospital but was not detained under mental health legislation; i.e. HL was an ‘informal’ patient, but had he tried to leave, he would have been detained.[1] HL lacked capacity to make decisions regarding treatment, so the clinical team made decisions that it believed were in HL’s best interest. The European Court of Human Rights concluded that there was a breach of Article 5(1) of the ECHR when HL was an informal patient, on the basis that, although the clinical team acted in what it believed to be HL’s best interests, there was no protection against arbitrary detention under these circumstances, as there would have been if HL had been legally detained (Eastman & Peay, 1998; Morris, 1999; Bartlett & McHale, 2003; Laing, 2003; Robinson & Scott-Moncrieff, 2005).

When considering whether or not there has been a breach of Article 5(1) in relation to any admission (voluntary or involuntary), the Court acknowledges a need to take account of a range of factors surrounding the admission:

> ‘In order to determine whether someone has been “deprived of liberty” within the meaning of Article 5, the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question’.[2]

The provisions of Article 5(1) may be applied not only to ‘persons of unsound mind’ who are physically detained in a psychiatric institution ‘in accordance with a procedure prescribed by law’, but also to individuals who are not physically detained in a psychiatric institution but are subject to other forms of control, such as living at home but under conditions determined by psychiatric ‘community treatment orders’ (Kelly, 2009*a*).

In relation to deciding who is and who is not of ‘unsound mind’, the European Court of Human Rights has made it clear that a diagnosis of mental disorder cannot be based solely on the individual holding views that differ from societal norms: according to the Court, a diagnosis of ‘mental disorder’ must be based on ‘objective medical expertise’.[3] If an individual is to be deprived of liberty, ‘the mental disorder must be of a kind or degree warranting compulsory confinement’ and ‘the validity of continued confinement depends upon the persistence of such a disorder’. In addition, ‘it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation […]. Mental illness may entail restricting or modifying the manner of the exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves’.

The *Winterwerp* judgment strengthened greatly the requirement that detention on the grounds of mental illness required objective medical expertise to support such a detention in the first instance (the so-called admission order). It did not, however, specify such a requirement for renewal of such detention orders. This matter is now of increased relevance in relation to the amendments to the Mental Health Act 1983 brought about by the Mental Health Act 2007 in England and Wales: under the unamended 1983 Act, the making of a renewal order, like an admission order, required an examination and report by the ‘responsible medical officer’ (sections 20(3) and (4)), but following the amendments introduced by the 2007 Act, the ‘responsible clinician’ (who may or may not be a medical doctor) can make out a renewal order, although they must consult with another ‘professional’ involved before doing so (Mental Health Act 2007, section 9(4)(b); amending Mental Health Act 1983, section 20(5A)). This may not meet the *Winterwerp* criteria for ‘objective medical expertise’ to support detention.

The *Winterwerp* judgment also emphasised that an individual detained on grounds of mental illness should have access to a ‘court’ to determine the appropriateness of detention, even if the mental illness required modifications in the manner of exercising this right. The Court was especially emphatic that if an individual is detained, 'the mental disorder must be of a kind or degree warranting compulsory confinement' and 'the validity of continued confinement depends upon the persistence of such a disorder'.

In emergencies, it may be difficult to obtain 'objective medical expertise' and the Court has determined that in such situations the protections of Article 5 are reduced; i.e. it may be neither feasible nor necessary to obtain 'objective medical expertise' prior to such a detention, although such detentions still must be in accordance with domestic law.[4] The rights to review of emergency detention, under Article 5(4), are also reduced,[5] although it appears likely that the duration of the emergency detention should be minimised, and non-emergency detention instigated in a timely fashion, if indicated.[6]

The determination of whether or not an individual's mental disorder is 'of a kind or degree warranting compulsory confinement' may be based on the individual's need for treatment and/or apparent dangerousness; i.e. apparent dangerousness may be sufficient to warrant detention of an individual with mental disorder.[7] In either case, individuals who are detained pursuant to the ECHR Article 5(1)(e) have the right to be informed promptly of the reasons for their 'arrest', as outlined in Article 5(2): 'Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him'.[8]

Conditions while detained

The European Court of Human Rights has articulated a need for detention to occur in a location that bears some relation to the reason for detention. For example, if an individual is detained because they are deemed to be of 'unsound mind', detention must occur in a therapeutic environment such as a hospital; the hospital wing of a prison would not suffice.[9] In such locations, once a specific treatment is based on medical necessity and shown to be in the best interests of the patient, procedures such as force-feeding or placing in isolation might not constitute breaches of Article 3 of the ECHR.[10]

A number of cases relating to detained individuals have referred to Article 8 of the ECHR, which outlines a right to 'private and family life' and states that any interference with this right must be 'in accordance with the law' and 'necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others'.

From a psychiatric perspective, it is conceivable that the psychiatric condition of certain individuals with mental disorder might deteriorate as a result of stimulation stemming from visits to them by family or friends. This is supported by observations that violent incidents among in-patients may be associated with recent contact with staff members, other patients and visitors. Although this evidence is somewhat inconsistent, this inconsistency is likely attributable to the small size, limited statistical power and low number of relevant studies (Bernstein *et al*, 1980; Phillips & Nasr, 1983; Powell *et al*, 1994). Notwithstanding these limitations, this literature at the very least suggests that there may, in certain cases, be a reasonable medical rationale for placing limits on visits for certain periods of time, for the 'protection of health'. From a human rights perspective, however, any such 'interference' must be proportionate to demonstrated need: in *Nowicka v Poland* [2003], for example, the European Court of Human Rights ruled that restricting family visits to once a month was not proportionate to, and did not pursue, any legitimate aim and was a breach of Article 8 of the ECHR.[11]

Regarding duration of detention necessitated by mental disorder, the Court has ruled that 'the validity of continued confinement depends upon the persistence of such a disorder'.[12] This is not an absolute requirement, however, as the Court recognises that it may not be appropriate to 'order the immediate and absolute discharge of a person who is no longer suffering from the mental disorder which led to his confinement' but that such discharge might best occur in a phased fashion, subject to conditions.[13]

In addition, if a patient remains detained for longer than necessary owing to the absence of community treatment resources that would facilitate discharge, the Court has not ruled against such detentions, consistent with its general reluctance to generate rulings that have might have substantial resource implications in various countries with differing models and levels of mental health services.[14] In the event, however, that a tribunal authorises discharge subject to certain conditions, and such a discharge does not occur (e.g. for resource reasons), that individual's continued detention is regarded by the Court as a fresh detention which must then be reviewed with 'requisite promptness'.[15]

Review of involuntary detention

Article 5(4) of the ECHR states that 'everyone who is deprived of his liberty by arrest or detention' shall be entitled to 'take proceedings by which the lawfulness of his detention shall be decided speedily by a court'. In the case of detention in mental health institutions, the meaning of 'court' is relatively wide, provided that the 'court' is independent of the executive and parties to the case, and is of judicial character (Bartlett *et al*, 2007).[16]

The European Court of Human Rights regards this requirement for review under Article 5(4) as separate to the question of the legality of detention under Article 5(1); i.e. there can be a violation of Article 5(4) as well as a violation of Article 5(1).[17] For example, the Court declared a breach of Article 5(4) in *HL v UK (Bournewood)* [2004],[18] on the grounds that, since HL was an informal patient, there was no adequate procedure for him to challenge his *de facto* detention.

The Court has placed particular emphasis on the necessity for mental health review tribunals (or similar bodies) to have the power to discharge formally detained patients, if they see fit. In the case of forensic patients in the UK, for example, such tribunals had, under the Mental Health Act 1983, the power to recommend release but could not discharge patients themselves; the European Court of Human Rights ruled that these powers were insufficient and the tribunals were subsequently given the power to discharge forensic patients.[19]

In 1981, the European Court of Human Rights delivered its judgment relating to section 65 of the Mental Health Act 1959, which gave the Home Secretary exclusive authority to discharge patients detained under hospital orders and impose restrictions on the discharge. The Court found that habeas corpus, the only form of review open to a patient recalled following apparent non-compliance with restrictions, did not constitute a form of judicial review sufficiently wide substantively to examine the justification of detention.[20] Following this ruling, the government enacted the Mental Health (Amendment) Act 1982, giving restricted patients the right to a binding mental health review tribunal (Gostin & Gable, 2004).

The European Court of Human Rights has specified that certain procedural safeguards are necessary to ensure that reviews of detention are effective (e.g. there may need to be a lawyer involved, even if the patient does not want one).[21] The Court has, in addition, provided guidance on the ECHR's requirement that 'the lawfulness of […] detention shall be decided speedily' (Article 5(4)). The Court has found that delays of 55 days[22] and 24 days[23] are not sufficiently speedy, suggesting that a maximum delay of approximately 2 or 3 weeks is likely to be acceptable, in the absence of specific requests by the patient for deferral (e.g. in order to seek independent medical opinion) (Bartlett *et al*, 2007).

Notwithstanding this range of mental disability-related topics dealt with by the European Court of Human Rights since its foundation, issues related to mental disability and mental disorder still seem underrepresented in the Court's activities as a whole (Bartlett *et al*, 2007; Prior, 2007). This apparent paucity of cases may stem, at least in part, from the absence of assertive legal advocacy for individuals with mental disability and the complexities involved in accessing European courts. The issue of advocacy could be addressed, at least in part, through the proactive provision of greater legal aid and advocacy services for individuals with mental illness, which would be consistent with the ECHR's positive obligation on states in respect of protecting human rights (Feldman, 2002). Problems related to the complexities of accessing European courts may also be addressed, at least in part, through the incorporation of the principles of the ECHR into domestic law in the UK (Human Rights Act 1998) and Ireland (European Convention on Human Rights Act 2003).

The European Union

The ECHR and the European Court of Human Rights are not the sole mechanisms dedicated to the promotion and protection of human rights at European level: in 1952 the European Court of Justice was founded in

Luxembourg. This is the highest court of the European Union (EU) and has the primary aims of ensuring equitable application of EU law across member states and reconciling provisions of EU law with national law within member states. Despite an initial reluctance to become involved in human rights issues, the European Court of Justice has now developed a significant body of jurisprudence in relation to human rights (Smith, 2007).

This EU commitment to human rights and the consequent importance of the European Court of Justice in terms of human rights, were enhanced in 1992 in the Treaty on European Union 1992 ('Maastricht Treaty'), which stated that 'the Union shall respect fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms' (European Union, 1992). Again, in 1997, the Treaty of Amsterdam further extended the role of the European Court of Justice in relation to human rights by bringing more provisions of the Treaty on European Union under the jurisdiction of the European Court of Justice (European Union, 1997; Smith, 2007).

In 2000, at the EU Summit in Nice, the Charter of Fundamental Rights of the European Union was adopted in order to 'strengthen the protection of fundamental rights in the light of changes in society, social progress and scientific and technological developments by making those rights more visible in a Charter' (European Union, 2000). De Búrca (2001) notes that the Charter emerged from an EU drafting process that was relatively open and experimental, in contrast with more usual, rather secretive processes associated with the EU. The contents of the Charter demonstrate a number of different influences throughout its drafting, including the Council of Europe's Convention on Human Rights and Biomedicine and the revised version of the European Social Charter, which came into effect in 1999 (Hervey, 2005).

The rights and prohibitions outlined in the Charter of Fundamental Rights of the European Union are generally consistent with those outlined in other, comparable documents, most notably the ECHR. Chapter 1, devoted to dignity, for example, outlines rights to 'human dignity', life and 'integrity of the person'; it also includes prohibitions on 'torture and inhuman or degrading treatment or punishment' and 'slavery and forced labour'. Chapter 2, devoted to freedoms, outlines rights to 'liberty and security', 'respect for private and family life', 'protection of personal data' and 'freedom of thought, conscience and religion', among others. Chapters 3 to 6 outline further rights on the themes of equality, solidarity, citizens' rights and justice, consistent with the provisions of the ECHR.

The implications of the Charter in terms of healthcare law and policy are not yet fully clear. In particular, although it is apparent that the Charter may raise awareness of issues related to rights and provide a context for subsequent debate, it is not at all clear whether it will drive or facilitate the development of solutions in various areas of healthcare policy in the EU (McHale, 2009). Conceivably, the very existence of the Charter may exert pressure on policy makers at both transnational and national levels to devise and implement policies that reflect the content and spirit of the Charter.

Consistent with this, Menéndez (2002) argues that the Charter has both symbolic and legal value in the EU despite the fact that it has not been incorporated into Union law but rather consolidates existing law. Lord Goldsmith (2001) highlights the Charter's intention to protect human rights by limiting the powers of EU institutions and emphasising that they cannot trample on the fundamental rights of citizens.

In Article 52, the Charter attempts explicitly to optimise consistency with the ECHR:

> 'In so far as this Charter contains rights which correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, the meaning and scope of those rights shall be the same as those laid down by the said Convention. This provision shall not prevent Union law providing more extensive protection'.

The issue of consistency is an important one. Although the European Court of Justice is part of the EU and the European Court of Human Rights is part of the Council of Europe, the European Court of Justice may, nonetheless, refer to case law derived from the European Court of Human Rights. While all EU member states have ratified the ECHR and are therefore under the jurisdictions of both the European Court of Justice and the European Court of Human Rights, the Treaty of Lisbon ('Reform Treaty') (European Union, 2008) provided that the EU itself would become a signatory to the ECHR and, as a result, the European Court of Justice would be formally subject to the rulings of the European Court of Human Rights. This would have the merit of possibly improving consistency in human rights case law in Europe, but the demerit of constricting and homogenising avenues of redress following alleged violations of human rights. The effects of an EU constitution may be similar, although its precise implications would depend on the text and the extent to which its provisions applied to all member states and were, in due course, interpreted by the European courts.

Human rights in national legislative form

The Human Rights Act 1998 in the UK

The Human Rights Act 1998 was introduced in the UK to 'give further effect to rights and freedoms guaranteed under the European Convention on Human Rights; to make provision with respect to holders of certain judicial offices who become judges of the European Court of Human Rights; and for connected purposes' (Preamble). The Act makes a remedy for breach of the ECHR available in UK courts (section 8); abolishes the death penalty (section 21); requires judges in the UK to take account of decisions of the European Court of Human Rights (section 2); and makes it unlawful for public bodies in the UK to act in a way that is incompatible with the ECHR (section 3), unless an act of Parliament dictates otherwise, in which case a 'declaration of incompatibility' can be made by a higher court (section 4).

The Preamble to the Human Rights Act defines 'Convention rights' to include all ECHR rights except for Articles 1 (requiring states to 'secure' ECHR rights to 'everyone within their jurisdiction') and 13 (right to 'an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity'). Section 2 requires that a UK 'court or tribunal determining a question which has arisen in connection with a Convention right must take into account' the jurisprudence of the European Court and Commission on Human Rights and the Committee of Ministers (of the Council of Europe) in 'so far as, in the opinion of the court or tribunal, it is relevant to the proceedings'. Section 3 requires that national legislation be interpreted in accordance with the ECHR as far as possible. This requirement applies not only to courts and tribunals, but to all parties interpreting legislation and is, arguably, one of the strongest provisions of the Act (Wadham *et al*, 2007).

Section 4 of the Human Rights Act states that if a higher court 'is satisfied that [a provision of primary legislation] is incompatible with a Convention right, it may make a declaration of that incompatibility', although such a declaration 'does not affect the validity, continuing operation or enforcement of the provision' and 'is not binding on the parties to the proceedings in which it is made'. Section 19 attempts to reduce the likelihood of such 'declarations of incompatibility' being made by requiring that a 'Minister of the Crown in charge of a Bill in either House of Parliament must, before Second Reading of the Bill' either make a 'statement of compatibility' with the ECHR or else explicitly acknowledge that 'he is unable' to do so but 'nevertheless wishes the House to proceed with the Bill'. In the event that a 'declaration of incompatibility' is ultimately made by a court, however, and 'if a Minister of the Crown considers that there are compelling reasons for proceeding under this section, he may by order make such amendments to the legislation as he considers necessary to remove the incompatibility' (section 10).

Overall, the Human Rights Act 1998 represents a significant recognition of the importance of human rights in the UK. Subsequent case law relating to the Act has involved a range of themes, including individual rights to privacy, objections against eviction from public lands by public authorities, and various issues related to immigration (Fenwick, 2007; Wadham *et al*, 2007). The Act has also been used extensively in the context of health and healthcare (McHale *et al*, 2007; Wicks, 2007) and provides an important mechanism for protecting rights in a variety of circumstances (Fenwick, 2007).

There are still, however, several important issues outstanding in relation the Human Rights Act. In a general sense, Wadham *et al* (2007) lament the perceived failure of the Act to create a culture of respect for human rights,

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and note that it is widely misunderstood and mistrusted by the public. Fenwick (2007) highlights another important issue by drawing attention to the extent to which the Act constitutes a bill of rights as opposed to simply being a means of giving ‘further effect’ to the ECHR; this matter is, as yet, unresolved.

The European Convention on Human Rights Act 2003 in Ireland

Irish law is rooted in the Constitution of Ireland (Bunreacht na hÉireann), which was enacted on 1 July 1937, came into operation on 29 December 1937, and has been amended more than 20 times since then (Government of Ireland, 1937; Hogan & Whyte, 2003). The Constitution establishes the principles of democratic government in Ireland and gives all citizens the right to vote (Article 16).

The central references to ‘fundamental rights’ are contained in Articles 40 to 44. Article 40 deals with ‘personal rights’ and states that ‘all citizens shall, as human persons, be held equal before the law’. Further, ‘the State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen’. In addition, ‘no citizen shall be deprived of his personal liberty save in accordance with law’ and ‘the State guarantees liberty for the exercise of the following rights, subject to public order and morality: […] The right of the citizens to express freely their convictions and opinions […]; to assemble peaceably and without arms [and] to form associations and unions’.

Article 42 deals with the ‘right’ to education: the state shall ensure that ‘children receive a certain minimum education, moral, intellectual and social’. Article 43 outlines the right to ‘private property’ and notes that the exercise of this right ‘ought, in civil society, to be regulated by the principles of social justice’. Article 44 outlines the right to religious expression, stating that ‘freedom of conscience and the free profession and practice of religion are, subject to public order and morality, guaranteed to every citizen’.

Economic and social rights are not mentioned in the Constitution, but Article 45 deals with relevant issues as ‘directive principles of social policy’ and states that ‘the State shall strive to promote the welfare of the whole people by securing and protecting as effectively as it may a social order in which justice and charity shall inform all the institutions of the national life’. More specifically, state policy shall be directed towards securing ‘an adequate means of livelihood’ for all citizens and ensuring that ‘control of the material resources of the community’ are distributed so as ‘best to subserve the common good’; ‘free competition shall not be allowed so to develop as to result in the concentration of the ownership or control of essential commodities in a few individuals to the common detriment’. In addition, ‘the State pledges itself to safeguard with especial care the economic interests of the weaker sections of the community, and, where necessary, to contribute to the support of the infirm, the widow, the orphan, and the aged’.

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The inclusion of these rights in the 1937 Constitution marked a notable departure from earlier drafts, which devoted little space to rights. Even when the 1937 Constitution was finally published, little attention was paid to the rights outlined in it, although, as Hogan & Whyte (2003: p. 1245) argue, these provisions have contributed significantly to the protection of the rights of the individual. Bacik (2001: p. 23), in contrast, notes it can be argued that the effects of constitutional rights in the lives of individuals in Ireland has been minimal, owing to both the belief system underpinning the Constitution and conservative interpretations by judges.

Relevant case law in relation to Irish Constitutional rights, however, demonstrates at least some evidence of growing judicial activism in this area throughout the 1970s. This trend was greatly strengthened by the increasing influence of the ECHR (1950) and Ireland's accession to the EU (1973), both of which, in large part, started to move Ireland towards a 'culture of human rights' by the 1990s (Bacik, 2001). This trend took a significant step forward in 2000 with the Human Rights Commission Act 2000. This Act found its roots not only in the slowly emerging emphasis on human rights in Irish and European courts, but also in the Northern Ireland Peace Agreement of 10 April 1998 (the 'Good Friday Agreement'), in which the Irish government agreed to 'take steps to further strengthen the protection of human rights in its jurisdiction'; 'establish a Human Rights Commission'; and 'introduce equal status legislation' (section 6, para. 9).

Consistent with this agreement, the Human Rights Commission Act (Preamble) aimed 'to provide further protection for human rights and, for that purpose, to establish a body to be known as 'an Coimisiún um Chearta an Duine' or, in the English language, the Human Rights Commission'. Section 2 defined 'human rights' as '(a) the rights, liberties and freedoms conferred on, or guaranteed to, persons by the Constitution, and (b) the rights, liberties or freedoms conferred on, or guaranteed to, persons by any agreement, treaty or convention to which the State is a party'.

The Irish Human Rights Commission was founded by the 2000 Act (sections 3 and 4) and its functions were to review state laws and practices relating to the protection of human rights; examine legislative proposals; make relevant recommendations to government; and promote understanding and awareness of human rights (section 5). It could also conduct enquiries (section 9), publish research and reports, apply to appear before the High Court or the Supreme Court as *amicus curiae* (or 'friend of the Court'), and, under certain circumstances, institute proceedings relating to 'any matter concerning the human rights of any person or class of persons'.

In 2006, 5 years after its establishment, the Irish Human Rights Commission had become active in a range of areas related to human rights, and, throughout 2006, received 242 communications from members of the public and 64 communications from organisations or in respect of legal proceedings (Irish Human Rights Commission, 2007). Almost one-third of communications related to the administration of justice (32.3%), whereas

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matters related to economic and cultural rights accounted for just 12%. During 2006, the Commission received 43 case notifications under the ECHR. The Commission's role in these cases was as *amicus curiae* and these cases involved a range of issues, including public housing, free legal aid assistance and various other matters. The Irish Human Rights Commission was merged with the Equality Authority to form the Irish Human Rights and Equality Commission in November 2014.

Consistent with this increased emphasis on human rights in Irish public life from the 1970s onwards, the ECHR was finally formally incorporated into Irish law in 2003, with the European Convention on Human Rights Act 2003. This Act aimed, primarily, 'to enable further effect to be given, subject to the Constitution, to certain provisions of the Convention for the Protection of Human Rights and Fundamental Freedoms' (Preamble). Using wording similar to the Human Rights Act 1998 in the UK, section 2 of Ireland's 2003 Act states that:

> 'In interpreting and applying any statutory provision or rule of law, a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions'.

Section 3 outlines the duty of all public bodies to adhere to the ECHR, stating that 'every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions'. Section 4 states that 'judicial notice shall be taken of the Convention provisions' and of the jurisprudence of the European Court of Human Rights, European Commission of Human Rights and Council of Ministers, and that 'a court shall, when interpreting and applying the Convention provisions, take due account of the principles laid down by those declarations, decisions, advisory opinions, opinions and judgments'.

The High Court or Supreme Court may make a 'declaration of incompatibility' when 'a statutory provision or rule of law is incompatible with the State's obligations under the Convention provisions' (section 5). Following a declaration of incompatibility, a copy of the declaration will 'be laid before each House of the Oireachtas' (Irish parliament) and 'the Government may request an adviser appointed by them to advise them as to the amount of […] compensation (if any)' (section 5).

The formal incorporation of the ECHR into Irish law represented a significant enhancement of the importance accorded to human rights in Irish law. It is notable that the European Convention on Human Rights Act 2003 has much in common with the Human Rights Act 1998 in the UK, especially in terms of its aim to give 'further effect' to the ECHR in domestic law (Preamble); the direction that interpretation of any 'statutory provision or rule of law' be consistent with the ECHR (section 2); the direction that 'every organ of the State' shall 'perform its functions' in a fashion consistent with the ECHR (section 3); the direction that national courts shall take 'judicial notice' of relevant ECHR jurisprudence (section 4); and the establishment of a procedure for a 'declaration of incompatibility' to be made by higher courts, when national legislation is incompatible with the ECHR (sections 5 and 6).

There are, however, also significant differences between the incorporation of the ECHR into national legislation in Ireland and the UK: whereas Ireland has a single, formal, written, unified constitution which guarantees various rights, there is no single, formal, written, unified constitution in the UK. In addition, in the UK, but not Ireland, there is a legislative requirement that ministers outline to Parliament whether or not proposed legislation is compatible with the ECHR; although this mechanism is unlikely to provide an absolute assurance of compatibility, bills in the UK can also be scrutinised by the Joint Committee on Human Rights in order to optimise compatibility.

More significantly, while the Human Rights Act 1998 in the UK presents a clear outline of the procedure to be followed in making a 'remedial order' following a 'declaration of incompatibility' (schedule 2), there are no similar guidelines or provisions in the European Convention on Human Rights Act 2003 in Ireland, apart from a procedure to award compensation to any 'injured party' (section 5). In addition, there is no provision for Irish courts to quash legislation that is found to be incompatible with the ECHR. Mullan (2008) argues that the reason given for such exclusions is that they help avoid a clash between the ECHR and the Irish Constitution, but this might have been prevented by stating that such powers must be exercised subject to the Constitution. In any case, it remains the position that if an Irish judge finds that a law is contrary to the ECHR but is without means to act upon this finding, it is likely that judges (of superior courts) will prefer to declare such a law to be contrary to the Constitution, with the usual consequent effect that it is struck down.

In Ireland, experience to date confirms that, while the principles of the ECHR are increasingly discussed in Irish courts, there is a tendency for cases to be decided by reference to the Constitution or domestic law rather than the ECHR or the European Convention on Human Rights Act 2003. In *TH v DPP*, for example, the applicant argued that a series of alleged irregularities during his trial had violated both his constitutional and ECHR rights, but when the High Court found that the delay violated his constitutional right to a reasonably expeditious trial, the court did not deem it necessary to proceed to consider arguments based on the ECHR.[24] Similarly, in *JF v DPP* the court found that there had been a breach of the constitutional right to a fair trial and went on to state that the ECHR did not provide additional rights above and beyond those already contained in domestic law in this matter.[25]

Overall, the passage of the European Convention on Human Rights Act 2003 has resulted in ECHR principles being discussed in an increasing number of cases in Irish courts; increased consideration of ECHR-related jurisprudence from other jurisdictions (e.g. UK) in Irish courts; and increased public awareness of the ECHR. Further experience is necessary to determine the precise interrelationship between ECHR rights and the Irish Constitution, and the extent to which the European Convention on Human Rights Act represents an effective incorporation of ECHR principles into Irish law, especially in relation to mental illness.

Human rights and mental illness: the United Nations and World Health Organization

United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)

The Universal Declaration of Human Rights (United Nations, 1948) and European Convention on Human Rights (Council of Europe, 1950) are general declarations of human rights. The most detailed declaration of rights in the specific context of mental illness is provided by the UN in its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991). These are summarised in Box 1.1 and emphasise that all people are entitled to receive the best mental healthcare available, be treated with humanity and respect, and receive mental healthcare based on internationally accepted ethical standards. In addition, mental health facilities should be appropriately structured and resourced, and an impartial review body should, in consultation with mental health practitioners, review the cases of involuntary patients.

Many of these principles were re-emphasised in 1996 in the World Health Organization's (WHO's) Ten Basic Principles of Mental Health Care Law (Division of Mental Health and Prevention of Substance Abuse, 1996) (Box 1.2), which require that all decisions should be in keeping with applicable law in the jurisdiction and not made on an arbitrary basis. Against this background, the WHO subsequently published the most detailed systematic set of human rights standards for national mental health legislation assembled to date, in the *WHO Resource Book on Mental Health, Human Rights and Legislation* (WHO, 2005).

In its *Resource Book*, the WHO sets out a 'Checklist for mental health legislation', detailing specific human rights standards which, according to the WHO, need to be met in each jurisdiction. These standards are clearly based on previous UN and WHO publications and centre on the provision of mental healthcare that is reasonable, equitable and in accordance with international standards. Mental health legislation in each jurisdiction has a key role in meeting these WHO standards, and in England and Wales civil mental health legislation meets 90 (54.2%) of the 166 relevant standards, while legislation in Ireland meets 80 (48.2%) (Kelly, 2011). Areas of relatively high compliance include definitions of mental disorder, procedures for involuntary admission and treatment, and clarity regarding offences and penalties. Areas of medium compliance relate to competence, capacity and consent; oversight and review (which exclude long-term voluntary patients);

Box 1.1 Key rights outlined in the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

- All people are entitled to receive the best mental healthcare available and to be treated with humanity and respect.
- There shall be no discrimination on the grounds of mental illness. All people with mental illness have the same rights to medical and social care as other ill people.
- All people with mental illness have the right to live, work and receive treatment in the community, as far as possible.
- Mental healthcare shall be based on internationally accepted ethical standards, and not on political, religious or cultural factors.
- The treatment plan shall be reviewed regularly with the patient.
- Mental health skills and knowledge shall not be misused.
- Medication shall meet the health needs of the patient and shall not be administered for the convenience of others or as a punishment.
- In the case of voluntary patients, no treatment shall be administered without their informed consent, subject to some exceptions (e.g. patients with personal representatives empowered by law to provide consent). In the case of involuntary patients, every effort shall be made to inform the patient about treatment.
- Physical restraint or involuntary seclusion shall be used only in accordance with official guidelines.
- Records shall be kept of all treatments.
- Mental health facilities shall be appropriately structured and resourced.
- An impartial review body shall, in consultation with mental health practitioners, review the cases of involuntary patients.

(Adapted from: United Nations, 1991)

and rules governing special treatments, seclusion and restraint. Areas of low compliance relate to promoting rights, voluntary patients (especially non-protesting, incapacitous patients), protection of vulnerable groups and emergency treatment. In both jurisdictions, however, mechanisms other than mental health law meet some of these WHO requirements. I explore issues relating to social justice (apart from dedicated mental health law) in Chapter 6, with particular emphasis on the UN Convention on the Rights of Persons with Disabilities (2006), the contents of which are outlined briefly next, by way of introduction to it.

United Nations Convention on the Rights of Persons with Disabilities (2006)

In 2006, the human rights landscape again changed significantly with the adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) by the UN General Assembly (United Nations, 2006; Bartlett *et al*, 2007). The CRPD commits signatory countries ‘to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental

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Box 1.2 World Health Organization's Ten Basic Principles of Mental Health Care Law

- Everyone should benefit from the best possible measures to promote mental well-being and prevent mental disorders.
- Everyone who is in need should have access to basic mental healthcare.
- Mental health assessments should be made in accordance with internationally accepted medical principles and instruments.
- People with mental disorders should be provided with healthcare that is the least restrictive possible.
- Consent is required before any type of interference with a person takes place.
- If a patient has difficulty understanding the implications of a decision, they should benefit from the assistance of a knowledgeable third party of their choosing.
- There should be a review procedure available for any decision made by official (e.g. a judge) or surrogate (e.g. a representative, guardian) decision makers, or by healthcare providers.
- In the case of a decision affecting liberty (hospital admission) and/or integrity (treatment) with a long-lasting impact, there should be an automatic mechanism for periodic review.
- Decision makers acting in official capacity (e.g. a judge) or surrogate (consent-giving) capacity (e.g. a guardian, friend, relative) must be appropriately qualified.
- Decisions should be in keeping with applicable law in the jurisdiction and should not be made on an arbitrary basis.

(Adapted from: Division of Mental Health and Prevention of Substance Abuse (WHO), 1996*b*)

freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (Article 1). It goes on to specify that 'persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (Article 1).

In the context of psychiatry, it seems clear that this definition of 'persons with disabilities' does not include all people with mental disorder, not least because many mental disorders (e.g. adjustment disorder) are not 'long-term' (Kelly, 2014*a*). The CRPD does not, however, present its definition of 'persons with disabilities' as a comprehensive one, but states that the term 'persons with disabilities' includes people with 'long-term' impairments; others, presumably, may also fit the definition. As a result, it is likely that some people with mental disorder meet the definition at least some of the time (e.g. an individual with an intellectual disability), but others do not (e.g. an individual with adjustment disorder). Moreover, the CRPD states that 'disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (Preamble); this de-links the definition of 'persons with disabilities' from any specific diagnoses and moves it into a social context.

Both mental health legislation and mental capacity legislation in various jurisdictions appear to violate the CRPD. For example, the CRPD specifies that 'the existence of a disability shall in no case justify a deprivation of liberty' (Article 14). If certain persons with mental disorder (e.g. some people with chronic schizophrenia) fit the UN definition of 'persons with disabilities', then mental health legislation in England, Wales and Ireland (for example) is clearly inconsistent with this provision, given the clear links that legislation in these jurisdictions draws between mental disorder, risk and involuntary admission (Kelly 2014*a*).

In relation to mental capacity, the CRPD specifies that persons with disability 'enjoy legal capacity on an equal basis with others in all aspects of life' (Article 12 (2)) and this appears violated by the fact that the remit of decision-making supports is limited in several jurisdictions. For example, Ireland's Assisted Decision-Making (Capacity) Bill 2013 excludes areas such as marriage and voting from its decision-making supports (section 106) (Kelly 2015*a*); in England and Wales, family relationships (Mental Capacity Act 2005; section 27), Mental Health Act matters (section 28) and voting rights (section 29) are excluded; in Northern Ireland, the Mental Capacity Bill 2015 has exclusions for family relationships (section 273) and voting rights (section 274). In addition, it is not at all clear whether or not the CRPD is consistent with any form of substitute decision-making, although there is some evidence that it may be acceptable in certain circumstances (Bartlett, 2012; Szmukler *et al*, 2014).

The Committee on the Rights of Persons with Disabilities (2014),[26] however, in its 'General comment' on Article 12 of the CRPD ('equal recognition before the law') is clear that even a 'functional approach' to assessing mental capacity is not an acceptable means for denying a person legal capacity, and that decision-making supports rather than substitute decision-making are appropriate. The Committee also specifies that developing a model of supported decision-making alongside a model of substitute decision-making is not sufficient to meet the CRPD requirement for 'equal recognition before the law' (Article 12). Regrettably, the Committee's comments, like the CRPD itself, leave unaddressed the uncommon but not unknown situation in which it is not possible to identify in any form whatsoever the 'will and preferences' of the individual.

Minkowitz (2007), a chairperson of the World Network of Users and Survivors of Psychiatry and member of the UN Working Group that produced the first draft of the CRPD, argues that all forced psychiatric interventions are by their very nature violations of the CRPD, requiring that perpetrators (i.e. mental health professionals) be criminalised and victims receive reparations. Minkowitz bases this argument on alleged violations

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of CRPD Articles 12 ('equal recognition before the law'), 15 ('freedom from torture or cruel, inhuman or degrading treatment or punishment'), 17 ('protecting the integrity of the person') and 25 ('health', especially the requirement for 'free and informed consent' for care). Current mental health legislation may also violate Article 4 (no 'discrimination of any kind on the basis of disability') (Szmukler *et al*, 2014). In the UK jurisdictions and Ireland, however, there are national laws permitting involuntary psychiatric detention and treatment under certain circumstances and, once such laws are observed, it appears unlikely that mental health professionals can be labelled as criminal. Dawson (2015), in particular, argues persuasively for a more realistic approach to interpreting the CRPD in this and other regards.

Conclusions

Although the 1700s and 1800s saw significantly increased emphasis on, and restatements of, key ideas about justice and human rights, the experiences of many individuals with mental illness remained unremittingly bleak, characterised by chronic neglect, social exclusion and, in certain cases, denial of liberty and dignity in large, overcrowded institutions.

Notwithstanding this situation, the general observance of human rights for most individuals, although not the mentally ill, took an important step forward in 1948 with the UN Universal Declaration of Human Rights (United Nations, 1948), followed in 1950 by the European Convention on Human Rights (ECHR) (Council of Europe, 1950). The ECHR had greater legal impact than the Universal Declaration of Human Rights and was given further effect in the UK through the Human Rights Act 1998 and in Ireland through the European Convention on Human Rights Act 2003. The ECHR provisions regarding liberty and reviews of involuntary detention have proven particularly relevant to people with mental illness, with a series of judgments that strongly emphasise various protections for the rights of the detained mentally ill, especially in relation to humane conditions in therapeutic settings and prompt, effective reviews.

As regards declarations of rights specific to the mentally ill, the most detailed statement to date is found in the UN's Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (United Nations, 1991), which articulate rights 'to receive the best mental health care available', 'live, work and receive treatment in the community' and access 'mental health facilities' that are 'appropriately structured and resourced'. In addition, 'mental health care will be based on internationally accepted ethical standards' and 'an impartial review body will, in consultation with mental health practitioners, review the cases of involuntary patients'.

The WHO's 'Checklist for mental health legislation' (WHO, 2005) details specific human rights standards that it believes should be met in each jurisdiction. Concerningly, mental health legislation in England, Wales and Ireland fails to meet many of these standards, chiefly (but not exclusively) in areas relating to promoting rights, voluntary patients (especially non-protesting, incapacitous patients), protection of vulnerable groups and emergency treatment (Kelly, 2011). However, mechanisms other than mental health law (e.g. mental health policy) may meet some of the WHO requirements, and I explore issues relating to legal and non-legal mechanisms for promoting human rights and achieving social justice for the mentally ill in Chapters 6 and 7.

Most recently, the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006) has presented the greatest challenges and opportunities for all who seek to build better protections for the rights of people with mental illness. The tone of the CRPD is typified by its stern requirement that 'the existence of a disability shall in no case justify a deprivation of liberty' (Article 14). While the potentially profound implications of this statement for mental health legislation are not yet clear (Kelly, 2014*a*), it is already apparent that this raises important issues about the primacy, enforceability and pragmatism of the CRPD (Dawson, 2015). This statement does not appear, for example, to permit any involuntary psychiatric treatment based on risk associated with mental disorder. This not only places all four jurisdictions that I examine in this book in clear violation of the CRPD, but also flies in the face of many centuries of history during which myriad democratically elected governments passed various mental health laws permitting involuntary care on the basis of mental disorder and associated risk to self and others.

From a clinical perspective, there are also concerning issues regarding the practical day-to-day application of some of the CRPD's provisions, including the position of the Committee on the Rights of Persons with Disabilities (2014) that developing a model of supported decision-making alongside a model of substitute decision-making is not sufficient to meet the CRPD requirement for 'equal recognition before the law'. This leaves unresolved the situation where it is not possible to identify in any form whatsoever the 'will and preferences' of a given individual. While the UN and the Committee on the Rights of Persons with Disabilities may not encounter these complex clinical dilemmas in their work, clinicians and families do encounter such cases, and the CRPD offers no useful guidance for these extreme situations. Indeed, the Committee creates additional obstacles by presenting critiques of 'functional' methods of assessing capacity, but not offering any alternative approaches and therefore not contributing to problem-solving in these extreme situations in any pragmatic way.

One possible result of this situation is that the CRPD may simply be ignored in practice or else deemed to be a campaigning document that overstates its case in order to correct the undeniable historical injustice against persons with impaired mental capacity. That would be regrettable, because there are many valuable, progressive and historically important aspects of the CRPD, such as the requirement that signatory countries 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities' and 'promote respect for their inherent dignity' (Article 1). This requirement for strong, assertive action to promote rights (and not just avoid impinging on them) permeates the entire CRPD, and provides patients, advocates and carers with a fresh and solid basis for more assertive action for the protection of rights not only in the legal sphere, but also in the realms of social advocacy and political activism (Kelly, 2014*b*).

I explore these matters in greater depth in Chapters 6 and 7, with particular emphasis on non-legal mechanisms for protecting and promoting rights. First, however, the critical role of mental health law in relation to human rights and justice is explored in some detail as concerns England and Wales (Chapter 2), Northern Ireland (Chapter 3), Ireland (Chapter 4) and Scotland (Chapter 5). In particular, I focus on the implications of mental health and capacity legislation for human rights and social justice, as well as the unique opportunities offered by current processes of legal reform in Scotland and, especially, Northern Ireland, where the CRPD appears to have played a critical role in determining the shape of change.